| Services (Including Amount, Scope, & Duration) | Possible Change(s) | Consequences | Fiscal Impact |
|---|---|---|---|
| **Physician services**<br>• Payment is approved for all medically necessary services and supplies provided by the physician (MD or DO) including services rendered in the physician's office or clinic, the home, in a hospital, nursing home or elsewhere.<br>• Payment is made for all services rendered by a physician within the scope of this practice and the limitations of state law, subject to stated limitations and exclusions. Exclusions provide for NO payment for the following general types of services:<br>➢ Drugs dispensed by a physician, unless it's established that there's no available pharmacy.<br>➢ Routine physical exams, unless of a type specifically allowed.<br>➢ Treatment of flat-foot. | Impose limits on the number of physician visits payable in any 12 month period. | This would not be supportable by IMS or patient advocates, or under federal law/regs that require payment for all medically necessary services. | Extremely difficult to know with precision. Would require detailed data runs with costly special programming. Some services that are currently payable that would be closely related to other currently excluded services may be candidates, such as reduction mammoplasty. |
| ➢ Acupuncture<br>➢ Unproven or experimental procedures, based upon Medicare criteria.<br>➢ Certain injections, if they aren't considered by accepted medical practice standards to be effective for the stated purpose or if administered for a purpose other than treatment of a specific illness or condition.<br>➢ Cosmetic/reconstructive surgery, with some stated exceptions (e.g. reduction mammoplasty for stated conditions). | Limit certain "medical" services that are now payable. | To the extent such services are currently within physician licensure and scope and aren't otherwise considered experimental (e.g. acupuncture), such would be hard to justify. | Difficult to know with precision for most services. Would require detailed data runs with costly special programming. This may be easier to determined for services such as reduction mammoplasties. |
| • Payment is made for other types of services, including:<br>➢ Mileage reimbursement (for provider), same as Medicare.<br>➢ Physician visits to patients in nursing homes once/month (more frequent visits require submitted documentation). | Limit or exclude other services "related to" otherwise covered medical services, e.g. reimbursement for mileage expense incurred by provider. | Probably wouldn't be real controversial among providers or result in huge savings, since most physicians don't submit claims for this | Probably negligible |
| | Decrease the payable frequency of physician visits in nursing homes (e.g. from 1/mo to 1/every other month) | IMS and nursing homes would probably fight this. This could also run afoul of federal requirements for payment of all medically necessary services. | Unknown<br>. |

| Services (Including Amount, Scope, & Duration) | Possible Change(s) | Consequences | Fiscal Impact |
|---|---|---|---|
| | Increase the types of procedures that require pre-procedure review or prior authorization | While this might result in some apparent savings, the costs attendant to the PA process may outweigh any savings. | Questionable |
| **Clinics**<br>Essentially the same scope as physicians, above. | Any changes that would be applicable to physicians, as above. | | |
| **Chiropractic services**<br>• Payment is approved for the same services that are payable under Medicare, using the same payment criteria. Payment is allowed for a differing maximum number of visits, within 3 diagnostic categories. | Eliminate the differential maximums by diagnostic category and simply impose an absolute maximum regardless of diagnostic category. Allow additional treatments only upon submission of documentation. | This might save a little money, but probably not substantial. | Potentially negligible |
| **Podiatric services**<br>• Payment is approved for certain podiatric services, as listed in the rules. | Impose limits on currently covered services or eliminate certain currently covered services. | This might save a little money, but probably not substantial, especially when considering that patients would likely seek replacement care from physicians. | Potentially negligible. |
| **ARNP services**<br>Generally speaking, ARNP services are afforded higher protections under federal law and regs, due to past discrimination. | Based on federal protections, any limiting of services would be difficult at best. | | |

| Services (Including Amount, Scope, & Duration) | Possible Change(s) | Consequences | Fiscal Impact |
|---|---|---|---|
| ➢ **Family/Pediatric ARNP services**<br>Payment is made for services provided by independently practicing family or pediatric nurse practitioners within their scope of practice, including advanced nursing and physician-delegated functions under a protocol with a collaborating physician. | Beyond addition of psychiatric ARNPs under fee-for-service Medicaid rules, no other changes recommended. | This proposed change will have negligible impact on FFS expenditures, since most of what they do would be payable under the Iowa Plan. Virtually all services that would now be paid to psychiatric ARNPs under FFS would still have been rendered and payable to a physician or to the same psychiatric ARNP incident to the physician. | To the extent payments would be made directly to the psychiatric ARNP and that such would be at 85% of the physician fee schedule, it is anticipated that there will be a potential cost-savings under FFS. |
| ➢ **Certified nurse midwife services**<br>Payment is made for services provided that are within the licensure and scope of practice of certified nurse midwifery. | Beyond the changes recently adopted by the DHS Council, no other changes recommended. | | |
| ➢ **CRNA services**<br>Payment shall be approved for anesthesia service provided by certified registered nurse anesthetists within their scope of practice. | No changes recommended. Anesthesia services rendered by CRNAs are less costly than if rendered by an MD/DO anesthesiologist. | | |

| Services (Including Amount, Scope, & Duration) | Possible Change(s) | Consequences | Fiscal Impact |
|---|---|---|---|
| **Birth center services**<br>Payment is currently made for prenatal, delivery, and postnatal services provided by licensed birth centers. | Since there's currently only one licensed birth center in the state, this provider type and service could be eliminated from Medicaid. | There would likely be resistance from nurse-midwives, the nursing ass'n, and others. Based upon minimal savings, not worth the effort. Further, this would probably cause increased scrutiny from the feds, to the extent that it would affect an otherwise "protected" provider type *(i.e. nurse-midwives)*. | Negligible |
| **Family planning clinic services**<br>Similar to ARNP services, family planning clinics are also afforded higher protections under federal law and regs, due to past discrimination. | Based on federal protections, any limiting of services would be difficult at best. | | |
| **RHC services**<br>RHCs are afforded their own protections under federal law/regs. | Any specific limitations related to their RHC status would be difficult, if not impossible. However, any limitations that may be applied to physicians could also be applicable to RHCs. | | |
| **FQHC services**<br>FQHCs are afforded their own protections under federal law/regs. | Any specific limitations related to their FQHC status would be difficult, if not impossible. However, any limitations that may be applied to physicians could also be applicable to FQHCs. | | |
| **CMHC services**<br>Payment is made for all reasonable and necessary services provided by a psychiatrist on the staff of a CMHC, as well as for services provided by a clinical psychologist, social worker or psychiatric nurse on the staff of the center, subject to certain conditions. | Because most CMHC services are rendered and paid through the Iowa Plan, effect on fee-for-service of any limitations in services would be negligible. | | |

| Services (Including Amount, Scope, & Duration) | Possible Change(s) | Consequences | Fiscal Impact |
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| **Psychologist services**<br>• Payment is made for services authorized by state law when they are provided by the psychologist in the psychologist's office, a hospital, nursing facility, or residential care facility. It's important to note that only psychologists meeting the standards of the National Register of Health Service Providers in Psychology are eligible to participate (i.e. independently enroll). All other psychologists may still provide services through a CMHC, psychiatrist, RHC, FQHC, or other enrolled providers.<br>• It's also noteworthy that most psychologist services are provided and paid under the Iowa Plan. Leaving relatively little volume under fee-for-service.<br>• The primary covered services include the following, and already reflect limits:<br>➢ Individual outpatient psychotherapy or other psychological procedures not to exceed one hour per week or 40 hours in any 12-month period.<br>➢ Couple, marital, family, or group outpatient therapy not to exceed one and one-half hours per week or 60 hours in any 12-month period.<br>➢ A combination of individual and group therapy not to exceed the cost of 40 individual therapy hours in any 12-month period.<br>➢ Psychological examinations and testing for purposes of evaluation, placement, psychotherapy, or assessment of therapeutic progress, not to exceed eight hours in any 12-month period. | Current limits could be reduced further. | This would result in some degree of savings, but at the price of consternation by psychologists and mental health advocates. Perhaps not a battle worth fighting. Further, to the extent that the bulk of psychologist services are provided/paid under the Iowa Plan, the savings under FFS would likely be less than significant. | Unknown, but likely to be negligible. |

| Services (Including Amount, Scope, & Duration) | Possible Change(s) | Consequences | Fiscal Impact |
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| **Organ transplant services**<br>• Payment is currently made only for specified transplants.<br>• Some do not require pre-procedure review, some do.<br>• Rules have been adopted and SPA to be submitted that will amend coverage policy as follows:<br>➢ Addition of coverage for pancreas transplants *(both pancreas transplants alone and simultaneous kidney/ pancreas),* subject to stated criteria and pre-procedure review by IFMC;<br>➢ Addition of coverage for heart-lung transplants, subject to stated criteria and pre-procedure review by IFMC;<br>➢ Clarification of covered diagnoses for currently covered liver transplants;<br>➢ Clarification of covered diagnoses for currently covered allogenic bone marrow transplants. | Eliminate currently covered transplants from rules and State Plan, or otherwise impose more narrow coverage criteria thereunder. | To the extent that currently covered transplants *(including those just added)* reflect current Medicare coverage policy and medical state-of-the-art, eliminating or otherwise limiting coverage would be difficult to justify. Further, eliminating or limiting transplants that have become accepted standards of care may run afoul of federal requirements regarding coverage of all medically necessary services. | ***$ Impact:*** Depending on what types of transplants might be eliminated or limited, the potential cost-savings would be significant, based on these procedures being big-ticket items. |
| | Impose absolute moratorium on approval of ETP requests for any currently non-covered transplant or for a currently covered transplants for non-covered diagnoses. | The extent to which similar ETPs have been granted in the past for similarly-situated individuals would make this difficult politically. However, current policy at 441—1.8(2)*"b"* provides that availability of funds <u>*is*</u> a criterion in considering whether an ETP will be approved. This would <u>*not*</u> extend to request for persons under 21, by virtue of the EPSDT mandate. | Depending on what types of transplants might be affected, the potential cost-savings would be significant, based on these procedures being big-ticket items. |
| **Sterilization services**<br>Sterilizations *(e.g. hysterectomies, tubal ligations, oophorectomies)* are covered, subject to timely and proper completion of the required sterilization consent form. | Elimination of coverage of these procedures is not realistic. | | |

| Services (Including Amount, Scope, & Duration) | Possible Change(s) | Consequences | Fiscal Impact |
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| **ARO services**<br>• Payment is made for specific services listed under the ARO rules when provided to adults with a chronic mental illness.<br>• These services must be rehabilitative in nature and may not be primarily habilitative and must be designed to promote the recipient's integration and stability in the community, quality of life, and their ability to obtain or retain employment or to function in other nonwork, role-appropriate settings.<br>• Payment is only made for services identified in a comprehensive plan, and then only on/after the effective date of that plan. Further, the recipient must be certified by an LPHA to be chronically mentally ill. | No changes recommended.<br>While the ARO Workgroup is in the process of proposing some revisions to current rules, no limitation of current services are recommended.<br>. | | Since payment is with county and federal funds *(except for state cases),* there is not a direct Medicaid cost impact. The only costs to the Medicaid program relate to fiscal agent costs for provider enrollment, claims processing/payment, etc |
| **Area Education Agency (AEA) services**<br>• Payment is approved for the health services delivered to children under IDEA. | No change recommended. Federal regulations state that Medicaid is a primary payor before IDEA. 75% of the federal funds are returned to the Medicaid budget. | | |
| **Infant and Toddler Services (Early Access)**<br>• Payment is approved for the health services delivered to children under IDEA. | No change recommended. Federal regulations state that Medicaid is a primary payor before IDEA. | | |
| **Lead Inspection Agency Services**<br>• Payment is approved to determine of the source of the poisoning for Medicaid children who have been lead poisoned. | No change recommended. Services to lead poisoned children are required under EPSDT | | |
| **Local Education Agency (LEA) services**<br>• Payment is approved for the health services delivered to children under IDEA. | No change recommended. Federal regulations state that Medicaid is a primary payor before IDEA. | | |
| **Maternal Health Centers**<br>• Payment is approved for the services provided to a woman during pregnancy | No change recommended. Federal regulations state that Medicaid is a primary payor before Title V (the federal maternal and child health block grant administered by IDPH) | | |

| Services (Including Amount, Scope, & Duration) | Possible Change(s) | Consequences | Fiscal Impact |
|---|---|---|---|
| **Rehabilitative Treatment Services**<br>• Payment is approved for the service components for Medicaid children receiving family centered, family preservation, and foster care services (either family or group setting). | No change recommended as the funding allows more children to receive these services. | | |
| **Screening Center Services**<br>• Payment is approved for the preventive physical and oral health services provided by local health agencies | No change recommended. Federal regulations state that Medicaid is a primary payor before Title V (the federal maternal and child health block grant administered by IDPH) | | |
| **Audiology Services**<br>• Payment is approved for audiologic testing when medically necessary services to establish the need for a hearing aid. | Establish limits on the frequency of hearing tests. | Would likely be opposed by the Iowa Association of Hearing Health Professionals and the Iowa Speech-Language-Hearing Association. | Likely to be negligible. There is no evidence that Medicaid recipients are abusing this service. |

| Services (Including Amount, Scope, & Duration) | Possible Change(s) | Consequences | Fiscal Impact |
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| **Dental**<br>• Preventive services – cleaning and fluoride are allowed every 6 months; sealants are limited to 1st & 2nd molars, through age ~~15~~ 18, once in a lifetime<br>• Diagnostic services – exams are allowed every 6 months, full mouth x-rays once in 5 years, bitewing x-rays once a year, other x-rays when medically necessary<br>• Restorative services – Fillings are allowed when there has been penetration of the enamel; stainless steel crowns are allowed when fillings won't work; 2 porcelain crowns are allowed per year. Crowns are not covered for adults age 21 and over.<br>• Periodontal services –Prior approval is required. Periodontal services are not covered for adults age 21 and over.<br>• Endodontic services – Root canal treatments are allowed for permanent teeth; prior approval is required for endodontic surgery on teeth roots. Endodontic services are not covered for adults age 21 and over.<br>• Oral surgery – Extractions and impactions are allowed when medically necessary<br>• Prosthetic services – Complete and partial dentures (bridges) are allowed once every five years. Removable dentures are allowed on front teeth and on back teeth when there are fewer than 8 back teeth that line up for chewing. Fixed dentures require prior approval. Relines are allowed once every 12 months. Two repairs per denture are allowed every 12 months. Adjustments are allowed when necessary after 6 months.<br>• Orthodontia services – Prior approval is required and is granted for only the most handicapping malocclusions, e.g. impaired ability to chew and digest food, jaw pain, susceptibility to cavities and inflamed gums, impaired speech. Orthodontia services are not covered for adults age 21 and over. | | Crowns, orthodontia, dentures are not available for adults age 21 and over. More teeth will require extraction. Overall health and nutrition would likely deteriorate as more people have no teeth and do not consume adequate nutrition. | $2,201,000 state dollars |

| Services (Including Amount, Scope, & Duration) | Possible Change(s) | Consequences | Fiscal Impact |
|---|---|---|---|
| **Drugs and Supplies**<br>• Payment will be made for drugs and supplies when prescribed by a legally qualified practitioner (physician, dentist, podiatrist, therapeutically certified optometrist, physician assistant, or advanced registered nurse practitioner) . | Impose limits on the number of prescriptions payable every month. | This would not be supportable by patient advocates. This might result in some apparent savings, but if the patient does not receive the medication, the cost attendant with increased physician visits and hospitalization may outweigh any savings. | Questionable |
| • **Prescription Drugs** shall be prescribed for a 30 day supply, however certain maintenance drugs, such as antidiabetic drugs, cardiac drugs and drugs for high blood pressure may be prescribed for up to a 90 day supply.<br>**:** Exclusions provide for no payment for drugs if the prescribed use is not for a medically accepted indication; drugs used to cause anorexia, weight gain or weight loss (except for lipase inhibitor drugs for weight loss); drugs used for cosmetic purposes or hair loss; drugs used to promote smoking cessation; fertility drugs; drugs classified as less than effective by the FDA and drugs marketed by manufacturers that have NOT signed a Medicaid rebate agreement.<br>**:** Payment will be made for certain drugs only when prior approval is obtained from the fiscal agent and when prescribed for the treatment of specified conditions. | Increase the co-payment of $1.00 per prescription certain recipients must pay. | This would not be supportable by patient advocates and may be controversial with providers, as no provider in the Medicaid program may deny services to an eligible recipient because of inability to pay a co-payment. Patients may not fill medication if they do not have the co-pay, resulting in increased cost due to physician visits and hospitalization, offsetting any savings. | This would be dependent on what type of co-pay structure was instituted and may be negligible if there are increased physician and hospital visits. |
| ➢ **Medical and sickroom supplies** are payable when ordered by a legally qualified practitioner for a specific use rather than incidental use in quantities up to a 90 day supply. Covered sickroom supplies include bedpans, canes, crutches, diabetic supplies, dressings, hearing aid batteries, vaporizers and other items. | | | |
| ➢ Certain **nonprescription drugs** are also covered when ordered by a legally qualified practitioner. These may be dispensed in 100 unit quantities or in the available consumer package. Some of the items included are aspirin, acetaminophen, multiple vitamins and minerals for pregnant and nursing women, other multiple vitamins and minerals with prior approval, and insulin. | Expand the number of drugs requiring prior authorization. | While this might result in some apparent savings, the cost attendant with the PA process may outweigh any savings. | Questionable<br>. |

| Services (Including Amount, Scope, & Duration) | Possible Change(s) | Consequences | Fiscal Impact |
|---|---|---|---|
| | Limit coverage of prescription drugs by eliminating classes of drugs that may be excluded from coverage as stated in the Social Security Act. Examples include cough and cold products, prescription vitamins and mineral products, nonprescription drugs, barbiturates, and benzodiazepines. | This would not be supportable by patient advocates. This might result in some apparent savings, but if these medications were not covered they would seek replacement drugs that are covered or may result in increased hospitalization. | Questionable savings |
| | Limit the number of brand name prescriptions a recipient may receive per month. | The pharmacist is already required to provide the least costly product that meets the order of the physician or practitioner. Some products are not available as a generic. There would need to be exemptions as well as a policy to review exceptions, which would result in an increase of administrative costs. | Questionable savings |
| | Implement a State Maximum Allowable Cost (SMAC) program to optimize savings with multi-source medications. | This program will supplement the Federal Upper Limit (FUL) Program already in place, to enhance savings on "A" rated generic equivalent products. This will reinforce the requirement of the pharmacist to provide the least costly product that meets the order of the physician or practitioner. | This will be a source of cost savings and is in the process of being implemented. Savings are contingent on the number of drugs in the program |

| Services (Including Amount, Scope, & Duration) | Possible Change(s) | Consequences | Fiscal Impact |
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| | Implement a series of prospective drug utilization (ProDUR) edits. | These edits do not change the therapy or therapeutic outcome for the patient and achieve cost savings without negatively impacting the pharmacists, physicians or patients. | This continues to be a source of savings through cost avoidance and was expanded November 2001. |
| | Enhanced retrospective drug utilization review (Retro-DUR) program. | This may reduce hospital admissions caused by inappropriate drug therapy, identify cases of medication overuse or abuse, or cases of high risk drug therapy. While this might result in some apparent savings, the cost attendant with this program may outweigh any savings. | Questionable |
| | Implement disease management programs. | These services are very complex and would require contracts with entities experienced in these areas. The Iowa Medicaid pharmaceutical case management, implemented October 1, 2000, focuses on pharmacy intervention to improve drug therapy outcomes. It is too early to determine the effectiveness of this program. The cost attendant with this type of program may outweigh any potential savings. | Unknown |

| Services (Including Amount, Scope, & Duration) | Possible Change(s) | Consequences | Fiscal Impact |
|---|---|---|---|
| **Durable Medical Equipment (DME) & Supplies**<br>• Payment is allowed for DME, prosthetic devices and sickroom supplies when they can be expected to make a meaningful difference in treating an illness or improving the functioning of a malformed body member. The amount payable is based on the least expensive item which meets the patient's needs. Repairs are allowed for patient owned equipment when the cost of the repair does not exceed two thirds the cost of replacing the item.<br>• Noncovered are: nonmedical items such as exercise equipment, first-aid or precautionary-type equipment, self-help devices such as safety grab bars and raised toilet seats, training equipment and equipment for the environment such as air conditioners, humidifiers, air cleaners, items basically for caretaker convenience such as stairway elevators; duplicate items; delivery, freight and postage.<br>• Wheelchairs are allowed for recipient's who cannot ambulate and who would otherwise be bed or chair confined. Power wheelchairs or scooters are allowed for recipient's who cannot propel a manual wheelchair. Special modifications such as seating systems, head rests, elevating leg rests are allowed when medically necessary. Only one form of mobility device is allowed. Separate reimbursement for wheelchairs for recipients in nursing facilities is not allowed. Repairs of recipient owned wheelchairs in nursing facilities is allowed.<br>• Recipients on home oxygen are allowed a portable oxygen system in addition to a stationary oxygen system when medically necessary. Separate reimbursement for oxygen for recipients in nursing facilities is allowed when the need for oxygen averages 12 or more hours per day for a 30 day period.<br>• Enteral nutrition ( intestinal tube feeding) requires prior authorization review every 6 months. Oral nutritional supplement (ie., Ensure) requires prior authorization every 6 months and is allowed when the supplement provides more than 51% of the daily caloric intake and regular food in pureed form is insufficient. Enteral feeding pumps are allowed when a gravity feeding set is not adequate.<br>• Prosthetic devices such as artificial eyes, arms and legs are allowed when necessary to replace a missing portion of the body, prevent or correct a physical deformity or malfunction or support a weak or deformed body part.<br>• Hospital beds and pressure relief mattresses are allowed for recipients who are bed confined or who require special positioning that is not feasible in an ordinary bed. | No changes recommended. | | |

| Services (Including Amount, Scope, & Duration) | Possible Change(s) | Consequences | Fiscal Impact |
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| • Sickroom supplies are allowed when prescribed for a specific medicinal purpose. Utilization controls vary according to the item and are established in the claims payment system. Sickroom supplies are not separately payable in nursing facilities.<br>• Diabetic supplies including test strips, lancets, blood glucose monitors are allowed for insulin dependent diabetics and are separately payable in nursing facilities. Utilization controls are established in the claims payment system. | | | |

| Services (Including Amount, Scope, & Duration) | Possible Change(s) | Consequences | Fiscal Impact |
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| **Hearing Aids**<br>• New hearing aids for adults are limited to once every 4 years unless prior authorized. Monaural hearing aids over $650 and binaural hearing aids over $1300 require prior authorization. | No change recommended. | | |
| **Optical & Optometric Services**<br>• Eye exams are limited to once every 12 months unless there is a complaint or symptom.<br>• Eyeglasses are allowed when there is a lens correction and the new lenses cannot be accomodated in existing frames.<br>• Contact lenses are allowed when vision cannot be corrected with glasses.<br>• Protective lenses and safety frames are allowed for persons with vision in only one eye children through 7 years of age and persons with a diagnosis related illness or disability where regular lenses would pose a safety risk.<br>• Noncovered services include cosmetic gradient tint, sunglasses, photogray lenses, no-line bifocals, a second pair of glasses.<br>• Prior approval is required for visual therapy and subnormal visual aids such as hand magnifiers and telescopic spectacles.<br>• Replacement of lost, broken or stolen eyeglasses for adults 21 years of age and over is limited to once per year unless the recipient is mentally or physically impaired. | Eliminate optometric and optician services (eye exams and eyeglasses) for adults.<br><br>Eliminate coverage for eyeglasses for adults. | Adults would need to find another resource to pay for necessary exams and glasses or do without. Counties may be asked to pay. Opthalmologist (M.D. eye doctors) services for removal of foreign bodies, etc. would increase.<br><br>Adults would need to find another resource to pay for eyeglasses. Counties may be asked to pay. | Would require a special data extract to calculate.<br><br>Would require a special data extract to calculate. |
| **Orthopedic Shoes**<br>• Orthopedic shoes and modifications such as inserts, arch supports, heel wedges, sole wedges are allowed when prescribed. Only one pair may be obtained on the same date, unless one pair is attached to a leg brace at night or is a pair of tennis shoes for children in school. | Limit new shoes for adults to only when necessary due to obvious wear. | Some recipients may experience additional foot problems if replacement of worn out shoes is delayed. | Difficult to determine. Likely to be negligible. |
| **Independently Practicing Physical Therapists**<br>• Coverage is limited to $1500 in any 12 month period.<br>• Services provided must be expected to either provide significant improvement in a reasonable and generally predictable time period or are necessary for safe and effective maintenance due to a specific disease state.<br>• Services such as general exercise to promote overall fitness and flexibility and activities to provide diversion or general motivation are not covered. | No changes recommended. | | |

| Services (Including Amount, Scope, & Duration) | Possible Change(s) | Consequences | Fiscal Impact |
|---|---|---|---|
| **Rehabilitation Agencies**<br>• Speech therapy, physical therapy and occupational therapy are covered in the recipient's home or care facility other than a hospital or intermediate care facility for the mentally retarded.<br>• Services must be reasonable and medically necessary and meet a significant need of the recipient that cannot be met by a family member, friend, medical staff personnel or other caregiver.<br>• Coverage is allowed for both restorative and maintenance services. | No changes recommended. | | |

| Services (Including Amount, Scope, & Duration) | Possible Change(s) | Consequences | Fiscal Impact |
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| **Independent Laboratories**<br>Payment is made for medically necessary diagnostic tests. | No changes recommended. | | |
| **Hospital Inpatient Services**<br>• Hospitals are reimbursed for inpatient care that is medically necessary based on diagnosis-related groups (DRG). The DRG payment includes all medically necessary services and supplies provided by the hospital.<br>• There are no specific limits on the number of days of inpatient care for which DRG payment will be approved, as long as the care is determined by the Peer Review Organization (PRO) to be medically necessary.<br>• To ensure that surgical procedures are medically necessary, the PRO conducts preprocedure reviews for certain procedures. The preprocedure review is conducted using criteria that have been developed by applicable specialties.<br>• A preadmission review is required for physical rehabilitation admission. Medicaid-certified physical rehabilitation units are paid a per diem rather than on a DRG basis. Continued-stay reviews are completed after 30 days and then every 15 days to determine continued hospitalization. Questionable cases are referred for physician review. | No changes are recommended. | | |
| **Hospital Outpatient Services**<br>• Payment will be approved for certain services provided by hospitals on an outpatient basis. These services limited by medical necessity and include emergency service, follow-up or after-care specialty clinics, general or family medicine, laboratory, X-ray, and other diagnostic services, outpatient surgery, and physical medicine and rehabilitation.<br>• Payment for outpatient hospital care is based on ambulatory patient group (APG) methodology, Medicare fee schedules (for stand-alone laboratory services), and Medicaid-determined fee schedules (for ambulance and observation bed services). | No changes are recommended. | | |

| Services (Including Amount, Scope, & Duration) | Possible Change(s) | Consequences | Fiscal Impact |
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| **NIP Services**<br>• Payment for noninpatient programs (NIPs) services is provided for alcohol or substance abuse treatment, cardiac rehabilitation, diabetic education, eating disorders treatment, mental health treatment (for fee-for-service Medicaid recipients), nutritional counseling, pain management and pulmonary rehabilitation<br>• Payment for NIP programs is based on Medicaid-determined fee schedules.<br>• All programs must meet a documented need in the area serviced by the hospital. The program must employ multiple treatment modalities and professional disciplines. Established parameters limit the program either in terms of its overall length or in terms of number of visits. | Providing these services is a cost saving measure, as these rehabilitation and educational services enable the patient to identify and correct conditions/situations that could negatively affect health.<br><br>No changes are recommended. | | |
| **Emergency Room Services**<br>• Payment is made for an assessment.<br>• Additional services are paid to an emergency room providing, the patient is evaluated or treated for a medical emergency, accident or injury, the patient is referred by a physician, the patient is suffering from an acute allergic reaction, or the patient is experiencing acute, severe respiratory distress. | No changes are recommended. | | |
| **Ambulance**<br>• Medicaid will pay for ambulance transportation by an approved ambulance service to a hospital or skilled nursing facility only when transportation by any other means could endanger the patient's health.<br>• Payment is approved when a patient is transported to the nearest hospital with appropriate facilities.<br>• Payment is approved when a patient is transported from one hospital to another if there is a valid documented medical reason for transporting the patient to the second hospital, i.e., a specific treatment is not available at the first hospital or the patient is from home or hospital to a nursing facility.<br>• A patient may be transported to the outpatient department of a hospital or to a physician's office for specialized services. The reason the patient cannot travel independently must be documented.<br>• Payment is limited to one ambulance service, if more than one ambulance arrives.<br>• Payment is also limited when a paramedic from one ambulance service joins another ground ambulance company already in transport. | No changes are recommended. | | |

| Services (Including Amount, Scope, & Duration) | Possible Change(s) | Consequences | Fiscal Impact |
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| **Ambulatory Surgical Centers**<br>Ambulatory surgical centers, which are not part of a hospital, are eligible to participate in the Medicaid program.<br>The center must be certified to participate in the Medicare program (Title XVIII of the Social Security Act).<br>• Covered surgical procedures must be medically necessary procedures that are eligible for payment under inpatient or outpatient care.<br>• Payment is based on the maximum allowable Medicare fee established by the Medicare program for the surgery and the geographic area of the ambulatory surgical center.<br>• Non-covered services include cosmetic surgery, reconstructive or plastic surgery for specific conditions that are excluded, abortions, and sterilizations for certain populations. | No changes are recommended. | | |
| **Psychiatric Medical Institutions for Children (PMIC)**<br>• Psychiatric medical institutions for children (PMICs) are eligible to participate in the Medicaid program if they are accredited by a federally recognized accrediting organization, have been issued a license by the Department of Inspections and Appeals, have been awarded a Certificate of Need from the Department of Public Health and have received written approval of need from the Department of Human Services, and are in compliance with all applicable state rules and standards.<br>• Outpatient day treatment is payable for children or adolescents. Outpatient day treatment also requires approval from the Department of Inspections and Appeals.<br>• Medicaid payment is available for PMIC services when child is determined to meet the level of care in a PMIC and the child is Medicaid eligible.<br>• The PRO completes level of care determinations for inpatient psychiatric services at the time of admission and on an ongoing basis for continued stays.<br>• Day treatment services for outpatient services are payable for children who are not inpatients in a medical institution or residents of a licensed group care facility and need day treatment services. Payment is made for day treatment services provided only in an approved site. Day treatment coverage is limited to a maximum of 15 hours per week. | PMIC level of care is more economically prudent versus inpatient care in an acute setting. No changes are recommended. | | |

| Services (Including Amount, Scope, & Duration) | Possible Change(s) | Consequences | Fiscal Impact |
|---|---|---|---|
| **Home Health Agency**<br>• Skilled Nursing is payable when preformed by a home health agency require a licensed registered nurse or LPN. Skilled nursing is on an intermittent basis defined as medically predictable recurring need requiring a skilled nursing service at least once every 60 days, not to exceed five days per week with an attempt to have a predictable end and shall be covered up to three weeks. Coverage of additional daily visits beyond the initial anticipated time frame may be appropriate short time period based on medical necessity. Daily visits or multiple daily visits for wound care and insulin injections are also covered.<br>• Home Health Aid Services are payable for unskilled services provided by a home health aid. Services are provided on an intermittent basis defined as services that are usually two to three times per week , not to exceed 28 hours per week. Increased services provided when medically necessary due to unusual circumstances for two to three weeks are also intermittent. HHA may be provided on a daily basis if the individual is employed or attending school and needs assistance with morning and evening activities of daily living to support their independent living.<br>• Medical Social Services-are directed to ward minimizing the problems an illness may create for the recipient.<br>• Physical Therapy-services directly related to the treatment of the patient's illness or injury and meet the guidelines for restorative, maintenance or trial therapy.<br>• Occupational Therapy – services directly related to the treatment of the patient's illness or injury and meet the guidelines for restorative, maintenance or trial therapy.<br>• Speech Therapy- services directly related to the treatment of the patient's illness or injury and meet the guidelines for restorative, maintenance or trial therapy. | No changes anticipated at this time for any services under this category. | | |
| **Intermediate Care Facility for Individuals with Mental Retardation**<br>• To provide health or rehabilitative services to persons with mental retardation or persons with related conditions and is receiving a continuous active treatment program, which includes aggressive, consistent implementation of a program of specialized and generic training, treatment, health services and related services directed toward the acquision of behaviors or the prevention or deceleration of regression or loss of current optimal functioning. | Establish a provider fee for Intermediate Care Facilities for the Mentally Retarded. | | Preliminary additional leveraged dollar estimate of $3,700,000 |

| Services (Including Amount, Scope, & Duration) | Possible Change(s) | Consequences | Fiscal Impact |
|---|---|---|---|
| **Home and Community Based Services (HCBS)**<br>• The HCBS Waiver programs provide service funding and individualized supports to maintain eligible consumers in their own homes or communities who would otherwise require care in a medical institution. Iowa has six HCBS programs that serve specific target populations: AIDS/HIV, Brain Injuries, Ill and Handicapped (serves individuals with disabilities) Mental Retardation, Physical Disability, and Elderly. | Consolidating the six HCBS programs. | Less confusion for the field and consumers. | None. |

| Services (Including Amount, Scope, & Duration) | Possible Change(s) | Consequences | Fiscal Impact |
|---|---|---|---|
| **Nursing Facilities**<br>Payment is made for care and services provided to residents in nursing facilities upon certification of the need for the level of care by a licensed physician of medicine or osteopathy, and approval of that level of care by the department.<br><br>Approximately 450 nursing homes provide care for the nearly 14,500 frail elderly and disabled adult Iowa residents as well as approximately 330 children who are not able to remain in their own homes. | Reduce payments to nursing facilities. | May cause some providers to no longer accept Medicaid recipients. Potential for an increase in rates charged to private pay residents which in turn may cause nursing home residents to qualify for Medicaid sooner. Potential for access and choice options to be reduced for those needing to enter nursing facilities. Potential for hospitals to keep lower level of care patients longer as fewer options for nursing facilities may be available. | To be determined. |
| | Require Medicaid-certified nursing facilities that serve Medicare and Medicaid populations to also be Medicare certified in order to receive Medicaid reimbursement. | Iowa has a large proportion of nursing facilities that are only Medicaid certified. If these facilities care for dually eligible residents (Medicare Part A and Medicaid eligible), Medicaid pays for the care that may otherwise be in Medicare obligation.<br><br>. | The result would be fiscal savings to the state and make Medicaid the "payer of last resort". The Department is currently preparing a comprehensive fiscal impact analysis to determine the extent of potential cost savings. Preliminary estimates indicate $1.0 M addt'l leveraged $ (general fund), Less: $0.035M implementation cost, Less: $0.006M on-going cost. |

| Services (Including Amount, Scope, & Duration) | Possible Change(s) | Consequences | Fiscal Impact |
|---|---|---|---|
| | Remove inflation factor provision under nursing facility case mix reimbursement methodology. | Current reimbursement policy allows nursing facilities' case mix rate to include an inflation factor | The Department is currently preparing a comprehensive fiscal impact analysis to determine the extent of potential cost savings. Preliminary estimates indicate a savings of $3.8M (state only $). |
| | Remove hold harmless provision under nursing facility case mix reimbursement methodology. | Current reimbursement policy allows nursing facilities to be "held harmless" from any reduction of their June 30 2001 Medicaid rate during the phase in to case mix. Facilities are paid either their phase in case-mix rate or their hold harmless rate, whichever is greater. | The Department is currently preparing a comprehensive fiscal impact analysis to determine the extent of potential cost savings. Preliminary estimates indicate State savings of approximately $4.7 million (state only $) annually. |

| Services (Including Amount, Scope, & Duration) | Possible Change(s) | Consequences | Fiscal Impact |
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| | Move to 100% case mix reimbursement | Based on legislative mandate, the department is transitioning to the modified price based case mix reimbursement methodology. The transition includes phase-in rates for SFY 03 by reimbursing facilities two-thirds of the modified price based case mix rate plus one-third of the rate the facility would have received under the old 70th percentile methodology. In addition, the mandate includes a provision that facilities are held harmless from any reduction of their June 30, 2001 Medicaid rate. Therefore, facilities are paid either their phase in case-mix rate or their hold harmless rate, whichever is greater. This would not be supportable by nursing home industry, as they worked very closely with State legislators in developing the phase in for case mix implementation. Establishing nursing facility rates by eliminating the hold-harmless would still ensure that nursing facility providers are adequately compensated and would also strengthen cost containment measures. | The Department is currently preparing a comprehensive fiscal impact analysis to determine the extent of potential cost savings. |

| Services (Including Amount, Scope, & Duration) | Possible Change(s) | Consequences | Fiscal Impact |
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| | Change reimbursement policy for nursing facility crossover claims | A crossover claim means a Medicaid claim filed on behalf of a Medicare beneficiary who is also eligible for Medicaid. The current reimbursement policy for nursing facility crossover claims provides for Medicaid payment of the full coinsurance and deductible amounts as determined by Medicare. Policy could be revised so that Medicaid would reimburse the nursing facility for coinsurance and deductible amounts only to the extent that actual payments from Medicare are less than the Medicaid allowed amount for the service. This will ensure that Medicaid does not pay more than the Medicaid allowed amount for such service. | Preliminary estimates indicate State savings of approximately $2.9M addt'l leveraged $ (general fund), Less: $0.06M implementation costs, Less: 0.015M on-going costs. |

| Services (Including Amount, Scope, & Duration) | Possible Change(s) | Consequences | Fiscal Impact |
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| | Change reimbursement policy for nursing facility bed hold payment. | The current bed hold payment policy is intended to ensure that a Medicaid resident who is absent from the nursing facility due to hospitalization, visitation or vacation is able to return to the same facility. Iowa Medicaid currently reimburses nursing facilities 75% of their established Medicaid rate for each day that a bed is reserved. (10 days per month for hospitalization and 18 days in any calendar year for visitation or vacation). There are several ways in which Medicaid payments for bed hold could be reduced: reduce the amount of payment from 75% to a smaller factor; reduce number of days that Medicaid would pay; apply minimum occupancy standard to the criteria and only pay for bed hold days to nursing facilities with occupancy above that standard. | The Department is currently preparing a comprehensive fiscal impact analysis to determine the extent of potential cost savings. Preliminary estimates indicate $.8M addt'l leveraged $ (general fund), Less $0.025 M implementation cost, Less $0.005M on-going cost. |

| Services (Including Amount, Scope, & Duration) | Possible Change(s) | Consequences | Fiscal Impact |
|---|---|---|---|
| **Transportation**<br>• Transportation may be of any type and may be provided from any source. If transportation is by car, the maximum payment that may be made is actual charge made by the provider for transportation to and from the source of medical care, but not in excess of the rate per mile payable to state employees for official travel. If public transportation, e.g. bus, is used, the basis of payment shall be the actual charge made by the provider of transportation. When public transportation is reasonably available to or from the source of care, it must be used.<br>• Reimbursement is also allowed for meals and lodging reimbursed at the state employees rate. | Reduce the rate of 29 cents per mile reimbursement to 28, 27, or 26 cents per mile. | If this service is removed or reduced this could increase necessary medical services. There is a high likelihood that such services would be provided on an inpatient or outpatient basis at hospital facilities, or increase physician visits, which would be an increase in actual costs because these are more expensive services. This could also result in the need for increased ambulance transport, which is even more costly. Medical transportation is very limited in the rural areas of the state. If the rate is reduced then there is the potential for medical services to increase. Also we could limit the number of trips per month but also may impact other areas. | Questionable as potential for cost shifting. |
| **Home and Community-Based Services** (Optional) **(AIDS/HIV, Brain Injury, Elderly, Ill & Handicapped, Mental Retardation, Physical Disability)**<br>• Services under the HCBS waivers must be cost effective and at or below the average daily cost of ICF/MR service. Many services under the waivers have a dollar cap. | Since this is an optional service under Iowa Medicaid it can be removed completely. | Removing this service would require replacing these services with other Medicaid services such as ICF/MR, nursing facilities, State Plan intermittent or EPSDT. The alternative to being on the wavier for many consumers would be institutionalization. | There would be no cost savings. |

| Services (Including Amount, Scope, & Duration) | Possible Change(s) | Consequences | Fiscal Impact |
|---|---|---|---|
| **Targeted Case Management**<br>Payment is made for this service to all persons who meet the criteria for this service. The eligibility for the service is determined by the provider. Payment is the same for each consumer not matter how actual contacts are made with or on behalf of the consumer. Once a consumer is approved as eligible for TCM the service continues for that person's lifetime, which in some cases may not be appropriate. | Prior authorization of this service by an impartial third-party organization such as Consultec medical review or IFMC instead of the case management agency determining this for themselves as the provider prior to provision of this service; reauthorization every year required. | This will reduce the number of persons who are receiving TCM who are not eligible TCM consumers. These consumers may not be able to find other services to assist them in meeting their needs without TCM. | This may have an up front cost, but in the long run will lower the number of ineligible consumers receiving the service, and lower the total dollars expended, while increasing the legitimacy of the FFP for this service. |